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The nature of recovery as lived in everyday experience

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Abstract

Background: Recovery in severe mental illness is often seen as an individual process that occurs in mental health settings. Recent research has begun to explore the nature of recovery as a social process. As a further exploration of this issue, this paper examines processes of recovery as they unfold in everyday life, attempting to capture both the simplicity as well as the complexity of the daily life experiences of people in recovery.

Aim: Exploring recovery within the context of the person's everyday life.

Method: Qualitative study, using narrative phenomenological methods, based on interviews with individuals in recovery.

Results: Four areas of everyday life experiences in recovery were identified: (i) having a normal life, (ii) just doing it, (iii) making life easier, and (iv) being good to yourself.

Conclusions: Conceptualizing recovery in severe mental illness within the context of everyday life offers the opportunity to understand mental health problems as an integrated part of people's lives. These findings suggest that recovery unfolds within the context of "normal" environments and activities. As one implication of this study, everyday life expertise should be included in the practitioners' agenda.

Keywords: *Recovery, mental health, everyday life, adaptation, narrative*

Introduction

Nearly 30 years ago, the Italian mental health reformer, Franco Basaglia (1987), criticized mental health care and practitioners for placing their main interest in illness entities rather than in the person experiencing the illness. From within the confines of the institution, Basaglia bemoaned the fact that when symptoms are not viewed within the context of the person's everyday life they become simply representations of an illness entity. Divorced from their natural occurrence within the social world, they come to be taken merely as reflective of diseases that are categorized in texts on psychopathology. It then only takes one additional small step in this same direction to equate the person with the illness, subsuming his or her humanity entirely.

Even though the institutions which Basaglia criticized for the most part no longer exist, his insights may be just as relevant today. Despite the fact that people with mental health problems have lived the majority of their lives outside of hospital settings for much of these previous thirty years, we still understand little about the ways in which symptoms and problems become manifest within the person's social environment and their impact on his or her daily life. That is, we do not yet fully understand the ways in which these symptoms and

problems may interfere with, complicate, or otherwise affect the person's day-to-day experiences, relationships, and pursuits. But if recovery from and in serious mental illness takes place within this social and material environment (Borg et al., 2005; Davidson & Roe, in press), and unfolds within the context of these same experiences, relationships, and pursuits (Davidson et al., 2005), then this is precisely the kind of understanding practitioners will need to accrue in order to be effective supporters of the person's own efforts to recover.

The present study was intended to contribute to a growing body of knowledge that attempts to explore, understand, and address severe mental health problems within the context of the person's everyday life. Drawing primarily on qualitative methods, this body of knowledge stems from a rigorous curiosity about the person who continues to exist behind, beneath, or beside a severe mental illness and about how the problems and challenges that are associated with the illness are experienced and addressed by this person within the context of his or her everyday life. Adopting an "everyday life" perspective, for example, highlights the importance of acknowledging the impact of "little things" in the person's life, such as meals, birthdays, or recreation; experiences and events which might otherwise be overlooked in studies that focus solely on illness and impairment (Davidson et al., 2006). Prior to introducing the objective and methods of this study in more detail, we provide a bit of background about this approach to recovery.

Perspectives on recovery and everyday life

Suggesting everyday life as a platform for understanding recovery requires some clarification. According to Gullestad (1989), the sphere of everyday life may be invisible precisely because it is too visible. As a result, she suggests two perspectives on everyday life that may help to elucidate its various components which are relevant for the present project. The first dimension is *organisational and functional* and refers to the concrete and daily organization of tasks and activities. Here we do not talk about a single everyday life, but many, influenced in complex ways by culture, social class, occupation, gender, age, and spiritual beliefs. It is about our patterns and systems of activities, what we do, how we do things, and the social and cultural contexts we live and move about in; issues in everyday life that are often unnoticed or regarded as too ordinary or commonplace to warrant attention.

The second dimension she identifies is everyday life as *experienced*. This has been referred to as subjectivity or what phenomenologists have described as the "life world" in contrast to the objective world of the natural sciences (Husserl, 1970). Here the focus is on the human experience of meaning, of what is salient and important to the person, rather than on facts or events per se. Daily life is also the terrain for our acts and our interactions with other people, and Gullestad emphasises how human beings attempt to integrate the various roles and parts of their lives through these experiences. This integration crosses different social structures and roles, like private home, work life, parental duties, and leisure, to mention only a few (Gullestad, 1989; Schutz, 1962/1999).

There is a range of practical skills which we often take for granted that are required to negotiate these different roles and activities in our lives. Navigating one's everyday life is made possible by having and making tacit use of a stock of practical knowledge that lies ready to hand, emphasizing that human experiences evolve in social as well as historical contexts. This is true of experiences of recovery as well, involving a dynamic process incorporating individual as well as material and social issues and in which the person is an active agent in his or her own life. Like everyone else, people with mental health problems need and possess to various degrees such a stock of knowledge, and attempt to develop

practical and social routines to sustain and maintain their daily lives. Once we acknowledge the importance of this sphere of everyday life and its various components, our major challenge both as researchers and as practitioners lies in making explicit, capturing, and recognizing the simplicity as well as the complexity of daily life among individuals with severe mental illnesses.

Objective and methods

The objective of the present study was to explore how individuals with severe mental illnesses experience the illness and its consequences within the context of their daily lives, and how they overcome these challenges and other barriers to find their place, a sense of meaning and purpose, and a valued social role as members of their community. Following previous research (Borg & Topor, 2003; Davidson, 2003; Davidson et al., 2005) we employed a narrative, phenomenological approach involving in-depth qualitative interviews intended to elicit information about participants' experiences, material and social situations, actions, and choices. Our questions were open-ended and concerned all areas of daily life, focusing on existential, social, and material issues as well as issues of health and illness. Follow-up questions were oriented to eliciting further information from participants, encouraging them to tell rich stories full of descriptive detail (Davidson, 2003). Additional information about the empirical phenomenological method used is provided below.

Participants

A total of seven women and six men were interviewed about their everyday lives and experiences. The interviews took place in settings chosen by the participants themselves, which in all cases except three was the person's own home. The study included people who: (i) had a permanent place to live, (ii) considered themselves as being in recovery or having recovered from severe mental illness, (iii) were coping satisfactorily with their lives, and (iv) had improved their lives with help from mental health services and/or with help from other sources. Participants had varied histories and experiences with different types of services and support systems, and had varied social situations. Their ages were between 26 and 54 years old. Two were married, two were engaged, nine were single, two had children, six had higher education (college or university), and two had ordinary jobs and income while the others were receiving disability payments but were all working part-time. Several reported having or having had financial problems that were a hindrance to a meaningful life in the community.

In terms of clinical presentation, ten participants had been treated for schizophrenia, one for reactive psychosis, one for manic depression, and one for paranoia. Time since illness onset ranged from under ten to over 35 years. Three people viewed themselves as having recovered from their illness, meaning they no longer experienced signs or symptoms of the mental health problems they were treated for, two experienced voices that still gave them trouble but felt they had gradually gotten more control over them, and the rest only had minor reminders of illness experiences, and, from their perspective, were living an ordinary life.

Procedures

Interviews were carried out by the first author during the time period 2004–2005. Each participant was interviewed twice, the first time in person and the second time either in

person or by telephone, following participants' preferences. The average length of each interview was between one to two hours. All but two of the interviews were audio-taped, transcribed into text, and then returned to each participant for review, approval, and possible alterations. Two participants did not feel comfortable being audio-taped and in these cases notes were taken and returned to the individuals for comments and verification instead.

The research process also included a reference group of five individuals with experience with recovery. Inspired by participatory research (Davidson et al., 1997), this group was involved in project design, interview content, and inclusion criteria, and in ongoing discussions during the analysis phase. Additionally the meaning of certain concepts was discussed. The group was run like a focus group organised by the first author. The contribution of the reference group was important in providing opportunities for in-depth discussions with people having first hand knowledge and expertise as well as providing a more comprehensive way of understanding the recovery process and people's lived experiences in a contextual way (Cresswell, 1998; Davidson, 2003).

A thematic and step-wise approach was taken to analysis of the interviews. This approach involved analysis of individual interviews for units of meaning related to everyday life, and then analysis across individual interviews, followed by grouping the material into provisional thematic categories. The third step involved returning to the interview transcripts to verify and supplement key findings. These findings were also continually discussed with the reference group; a step considered critical to the ensuring the trustworthiness of the study and its validation (Cresswell, 1998; Malterud, 2003). The study received prior approval from the National Social Science Data Service and at the regional level from the Region IV (Mid-Norway) Medical Ethics Committee. Finally, we have changed the names and identifying features of the participants to protect their privacy.

Findings

We identified four major themes described as being normal, just doing it, making life easier, and being good to yourself. Each of these is described in more detail below.

Being normal

Achieving normality takes on very concrete meaning in the participants' stories. What seems most crucial to "being normal" is spending time in ordinary environments with ordinary people. As one participant whom we will call Susanne described:

Ah, I would describe it [recovery] probably as functioning as normal, in term of . . . I work and that takes a big, big chunk of my time and energy, probably too much. I am married, and that's a big chunk that, yeah a very central part. I think the normal things of hanging on and doing those things we have to do, like shopping and cleaning and paying bills and having resources to keep living.

Rather than some lofty pursuit of health or well-being, being normal, from the perspective of the study participants, was described in these kinds of practical terms: shopping, cleaning, and paying bills. These and other activities of daily life which otherwise may be taken for granted, but when they are experienced as difficult become embarrassing, troublesome, and annoying. The stories told in this study are for the most part about individuals trying to get on with their lives in these mundane and practical ways in spite of

mental health problems, being occupied with the independent pursuit of ordinary activities.

At other times, however, participants like Nina experienced consequences of their mental illness that had to be managed in order to maintain her life in a normal setting. Nina, for example, tired easily but found her ability to cope nonetheless to be very gratifying:

These things like having to deal with bills, dealing with insurance companies, dealing with all kinds of practical things . . . You struggle to get things done, to make things function in an alright way . . . and all this responsibility. I'm alone. Many are two and that can actually be easier. When you're alone you have all these practical things and you're responsible for them yourself, a lot and all by yourself. But at the same time you don't want to swap with anybody, because it's wonderful too. And it's such a satisfaction that you actually can cope with it. That I find very positive.

A struggle and frightening at times when it came to all the responsibility that everyday life involved, but Nina wouldn't have had it any other way. She felt pleasure and pride in being independent and accepted the worries associated with this.

Experiences of being normal also involved being situated in common social settings and environments, and fulfilling common roles, like being with parents, siblings, or spouses and children. The family represented continuity and stability. Being a mother to her children required Anna to take them to the school bus in the morning despite the fact that her heavy medication made her look a bit odd and other children on the bus commented on it. Continuing to be a mother and taking care of these daily responsibilities was extremely important for her and, in addition to accompanying her children to the bus, involved making sure that her children's clothes were clean and neat, that they had food and drinks in their lunch bags, that dinner was ready when they returned home, and that she was able to join in on parents' evenings.

Family life offered regularity in contact and activities, like having dinner together during the week, taking the family dog for walks, or visiting and helping each other with practical things, like many families often do. This did not necessarily mean that it was the person with mental health problems who was helped. Giving and taking more generally was emphasized and this seemed to be based more on traditional family patterns than illness-related roles. When Anna was admitted to the acute admission ward, and described herself as very psychotic, for example, her sister called her as usual and discussed their brother's birthday present. And in the often chaotic environment of the acute ward, she rang her children every evening at 8:00 p.m. to say goodnight and to sing their regular prayer song.

Having a job was also a part of being normal. This was not necessarily an 8:00 a.m. to 4:00 p.m. job, but a work situation that was experienced as valuable and meaningful, and in a regular setting as opposed to sheltered occupation. Working gave participants a chance to spend time in ordinary environments and offered respite from psychiatric settings which were experienced as artificial. Participants enjoyed talking about the headlines in their local newspaper, for example, or about anything else that could come up at lunch breaks. They wanted to learn more about the world around them and be in contexts in which normality was expected of them. A few participants held ordinary jobs but most had jobs that had been adjusted to the person's needs in some ways, mainly in terms of flexibility in working hours. What "being normal" can seem to add up to is finding or being introduced to situations that permitted and supported the participants in stepping out of the problematic arenas of their

lives (e.g., psychiatric settings) in order to be just an ordinary person carrying out ordinary activities, offering the person the feeling of being one of the (normal) crowd as opposed to being a mental patient among other mental patients.

Just doing it

In addition to resuming ordinary activities with ordinary people, being in recovery appears to require the person to do something concrete to improve his or her situation, as Susanne explained:

I identify with the Nike slogan: "Just do it!" Just do it! It's about having to do it. Yeah, really... I probably think about the things that I don't think it is, and that about when someone else decides for me... When I read about recovery written as goal-driven... that can only be written by practitioners because how many of us get up in the morning and say: How am I going towards my goals today? That is not something that you do.

Rather than being the playful, rational, and stepwise process suggested by treatment plans, initiating recovery appears to be experienced as a somewhat desperate effort to break out of a cycle of recurrent problems associated with mental illness, like hearing voices, losing touch with friends, or being preoccupied by worries. Participants reported various ways of finding sources of hope and inspiration to carry on and of discovering pathways toward a better life. Despite the tug of despair, they never gave up and highlighted the importance of continuing to believe in their capacity to recover. As Susanne suggested, the practicalities of recovery can be summed up as "just doing it"; being creative in dealing with your problems, looking again and again for new solutions, and discovering what works for you.

In addition to believing in themselves, participants found that positive expectations and having the faith of other people were helpful. Susanne talked about her husband as a very important supporter who did not accept her staying in bed all day. Anna mentioned her family who never had given up and continued to expect her to get well. In spite of her distress, they expected her to get up each morning to take care of the house and the children. And Johanne referred to her boss:

We have a friendly fight between us, where we... I challenge him to do work better and he does it best of course... And then I really have to keep it up and he puts high demands on me that are pretty high for me, actually, so I strive for them... And that's good to have. It's okay that I haven't reached the top, that I can do even better, that I have something to reach for, that he has high expectations.

Participants described recovery as involving action, as "doing it". In the context of the individual's life situation, he or she work alone and together with others, finding out how they can live with the presence of side effects like obesity and drowsiness, or live with unemployment, lack of energy, and being poor, or with worries about what using medication could do to their bodies over the years. Recovery was described as an integrated part of life, in which a central issue was about discovering ways to be in charge and in which finding a sense of balance between rest and activity was essential.

For some participants, accepting that they had mental health problems meant accepting limitations in their lives, not being able to take part in as much as they used to or would have

liked to do. “Just doing it” did not imply that these choices or actions were easy or straightforward, but that they were essential to moving ahead in life, regardless of how goal-directed or planned it might be and regardless of all of the other competing issues and demands.

In all of this, discovering the value of “little things” and finding pleasure in managing small tasks others might see as trivial were highlighted. Even if life turned out differently than expected, participants felt there were opportunities in their future. And although many mentioned that in the back of their minds they worried at times about getting sick again, hopes and dreams for a better life, and expectations of getting well, were nonetheless very present.

Making life easier

“Making life easier” referred to social situations, other people, and coping strategies that were experienced as helpful in the recovery process. Although most of the participants had some contact with practitioners, often general/primary care practitioners, and used some kind of medication, it was in the context of everyday life that they worked on their recovery, tried things out, failed and succeeded, and fell down and got up on their feet again. Within this context, participants recognized and appreciated many factors that were supportive and important in their being able to get on with their lives.

As one source of support, participants described many professionals who were helpful, and identified their helpfulness as various ways in which they contributed to making their struggles more bearable and/or improving their daily life situations. Emma exemplified this in describing a good practitioner she had met:

I experienced him as very wise and kind of . . . it didn’t seem like he practiced any theories on me, but rather responded to what I said and had experienced. He had a lot of experience in his profession, but seemed very wise to me, and very . . . like . . . he understood more about me than I did and sort of reflected when I said something and then could better understand what I had talked about.

Practitioners who were available, who recognized the need for assistance or support in all kinds of practical matters, and who did not give the impression of primarily being interested in symptoms and problems were highly valued. The stories of recovery participants told included many paradoxes and unpredictable situations, revealing that “getting on with life” is not easily planned and does not always follow a well-defined or pre-determined pathway. Having service systems available also made life easier. For Martin one special hospital ward offered him a sense of security:

Yes, I’ve used one ward at the hospital as an asylum, collaborate with them when problems get worse. I’ve got a deal when I can go there without all kinds of bureaucracies. I can just call and then go there.

Another aspect referred to as helpful was having adequate material and instrumental resources, like having a home you could feel safe in and get pleasure from. As Anna mentioned:

I like sitting by the kitchen table and thinking things over . . . I really like that. I sit in the kitchen on a tall chair . . . It is a good place.

Similarly, Paul described:

On not so good days I stay at home in the apartment, try to find peace here. Otherwise I enjoy walking and cycling . . . I have lived here for 6 years. Have a rental contract for 1–2 years at the time. Like it here. It's central.

Home was described as a place where the person could relax and find peace. A safe place was central in order cope with all the daily challenges. Several participants expressed gratitude for a pleasant home where they had made great efforts in decorating and furnishing it in their own way. Having the home as a platform from where they could approach the larger community was also important. From their home they could find ways to encounter and form relationships with the community, like going for a walk in the park or in the woods nearby, going to work, to church, to hobbies like swimming or gardening or bicycling, or to meet friends. As for most of us, having a stable income and accommodation made living easier, with or without mental distress.

In several instances, participants' references to material resources were implicit in their discussions of activities that fostered recovery. Pursuing interests, making your home neat and pleasant, being with friends, and in general being occupied with meaningful activities were described as helpful:

It's important to have things to do that give meaning. I go for walks a lot in the area here, maybe start the day by turning on the PC, then take a turn tidying. For me it is important to have 1–3 things to do that are good. Situations of doing nothing promote illness for people with serious mental illness. I need some on-going projects . . . those are good things.

Although people found different pathways to recovery, some general themes emerged, like endurance, not giving in, and finding out what makes life easier. George used alcohol as self-medication for a long period in order to cope with voices and anxiety until he developed his own meditation method and found professional help. Martin experienced troublesome voices and visions but has found some ways of keeping them at a manageable distance by enjoyable occupations. Emma prayed every evening. She found it relieving and relaxing with evening prayers when she could go through the day's events and find peace before bedtime: "It gives an inner peace in crisis, praying, and by that keep things in place." Paul found a kitten outside his apartment building. He wrote a letter one year after the initial interview as he wanted to inform us about what really had made a difference in his recovery. Finding this kitten made him think less about the voices and troublesome sides of life. And having a cat required of him to go out and get cat food and this again brought him in contact with new people through talking about his cat. Participants appeared to find ways to use available opportunities and events to engage in meaningful and pleasurable activities that offered respite to, and carried them beyond limitations imposed by, illness.

Being good to yourself

A variety of situations were mentioned that created good feelings, gave peace for a shorter or longer while, or gave participants pleasant memories to look back to for comfort. Spoiling yourself, giving yourself a treat, and taking care of your body were examples of "self-nutrition" or "vitamins" mentioned in the interviews:

I feel I get so much back for the good experiences, and I can take them up again if I feel down and low, then I can think about the good moments. I find good experiences so important. You get much more out of them than things and that kind.

People often need vitamins as supplemental nourishment in order to build up and maintain vital bodily processes and to prevent illness. In recovery, finding useful kinds of “vitamins” appeared essential. In the above, Emma talked about some of the things that kept her going. Being good to yourself could be a solitary activity, as in Kristin enjoying her evenings alone by the TV, or when George was meditating, listening to music, or watching debate programs. It could also be a social event, as it was for Emma when she met her friends at cafés or travelled with them to cities in Europe.

Activities in the community bring up a crucial issue in recovery which pertains to cost. Taking care of yourself, like pursuing hobbies and interests and enjoying the company of friends, requires resources. Having a car was necessary for Johanne in order to maintain contact with her old neighbours. They meant a lot to her. Travelling and visits to cafés required Emma to sacrifice fixing up her flat. And the dream of a holiday might seem far away for Frank as his financial situation was hazardous. The immaterial meaning of material resources was very clear and great consideration was often given to how to spend a limited amount of money.

In addition to social or individual events, “vitamins” involved concentrating on a healthy life style. As Susanne said:

A really nice part for the moment is keeping healthy. I have put a lot of energy into trying to get fit and healthy and the commitment to anything that will keep me well . . .

Several participants had developed expertise on health food and diets and established new routines for their meals. Some went to the gym, had regular walks, or were concerned with staying in a good physical shape.

Historically, patients and clients have been viewed as being on the receiving end of their relationships with others, and rarely have had the opportunity of giving back. In the narratives in this study the wish to give back came forth as a prominent theme. This wish involved sharing their experiences in writing or talks, offering advice or practical help to others, or just being a decent fellow human being by helping out in whatever way was needed in the neighbourhood. Emma gave this example:

I have given priority to giving, treating people well . . . when I've had the opportunity. Not just to be that kind, but I somehow like giving more than receiving. Friends say that I am a caring person. I write rhymes on birthday cards and things like that to special people, mainly girlfriends . . . Yes, I enjoy when people show they appreciate me and therefore I want to show them that I appreciate them.

As the participants in this study tell us, being good to yourself may involve being good to others as well. Human relations and friendships are developed through sharing, caring, and reciprocity. Always being in the position of receiving and always being the one who is helped represents an unbalance that participants found it important to redress.

Discussion

Four areas of everyday life experiences in recovery were elicited through this study; the importance of having a normal life; initiating recovery by “just doing it”; finding ways to

make life easier, and the value of being good to yourself. In response to the descriptions offered above, which characterize each of these themes in everyday terms, it is reasonable for readers to wonder, however, what any of this has to do with severe mental illness, as one of our colleagues asked upon reading a draft of these findings. The struggles that participants described seem like the same common human struggles we all share, and few of their solutions had anything specific to do with their illnesses. How can exploring everyday life issues in this way be helpful for individuals with mental illness, or for those practitioners who are dedicated to assisting them in their recovery?

These are good questions and a reminder of the significance of Gullestad's (1989) point made earlier about everyday life being invisible because it is too visible. In order to give our colleague and sympathetic readers some answers, we would like to focus in closing on four implications which this approach generates that have utility for practice.

First, when it comes to understanding recovery, the trivialities of everyday life must be seen as anything but trivial. As opposed to abstract diagnostic categories or symptoms which occur in a pure state (i.e., in a vacuum), these trivialities are what individuals with lived experiences of mental illness mainly talk about, because mental illness poses practical problems and affects their everyday life in a variety of ways. The participants in this study mentioned disturbing voices, fatigue, poverty, side effects of medication like drowsiness and obesity, anxiety, and sleep disturbances. Mental illness had among other things caused them difficulties in fulfilling their education and vocational aspirations, organizing their daily lives, paying their bills, and making and keeping friends. As reported in prior research (Mezzina et al., 2006), these findings support the view that recovery is an inevitably social process as well as an integrated part of the person's daily life. Recovery is described by the participants as an ongoing process that unfolds in a variety of contexts, in which actions and activities can be planned or events can happen in unplanned ways that have great impact on the individual's situation. It is these small bits of life that are often experienced as being of critical importance in an individual's recovery process.

Second, individuals being diagnosed with schizophrenia or other severe mental illnesses do not describe a life history characterised by a disintegrated sense of self or by having lost their overall ability to function. Persons experiencing severe mental illness appear not to lose themselves entirely (Davidson, 2003; Strauss, 1996; Topor, 2001). As seen in the findings above, participants described a life full of interests, skills, and expertise which they had acquired before illness onset that remained useful to them in their recovery, and that reminded them of how life could be. They reported on material and social conditions that were helpful and on their own determination and hard work as central elements. Participants presented themselves as individuals in a social and cultural context, in which social norms and culturally-favoured activities were as much part of their daily lives as for people in general; activities like going to the gym, going for walks, or supporting your family. Self-care was also a highlighted area. Examples of physical self-care, emotional self-care, and spiritual self-care were mentioned, as well as coping strategies developed in creative ways.

When participants described things they could do to make life easier, they mentioned examples like the intense pleasure of standing under a tree and enjoying nature, meditation, music, gardening, or beating your own record on the exercise machine. Building on strengths and pleasures make it easier to carry burdens and encounter troubles, and to maintain their belief in their capacity to recover. Participants also described situations of being ill and well at the same time, but most importantly they had

resources, skills, and courage that made recovery possible. Human problems and symptoms cannot be understood or interpreted divorced from this context of the person's overall life.

Third, normal environments and activities emerged as the most common and effective arenas for recovery in contrast to mental health service settings. Ordinary community arenas, ordinary work, and ordinary homes comprised participants' preferred life worlds. These arenas gave meaning and invited them to participate in discussions of general topics as opposed to remaining confined to a discourse focused on illness. Most of the participants also talked about the value and meaning of people believing in them or expressing expectations of competence and action. In addition, they had kept their position and role as a family member or friend or neighbour as opposed to being "mad" or becoming only a "mental patient". Within this context of normal life, mental health services and professional competence had a rightful place and proved to be invaluable in many situations. But even in these cases, the key competence of practitioners was to allow participants to be human and to be normal, with all of the rights, responsibilities, and requirements that being ordinary citizens involve.

This brings us to the fourth, and final, implication for practice. Rehabilitation and treatment programs will do well to elicit, listen to, and appreciate both the dramas and the trivialities of everyday life, as well as the individual's own expertise in managing these tasks. Living conditions, income, employment/unemployment, and social interactions outside of treatment settings are central to processes of recovery and cannot be seen as lying outside of the scope of clinical or rehabilitative practice. People with severe mental illnesses are neither defined by, nor limited to, their symptoms or diagnosis. Conceptualizing recovery within the context of the person's everyday life moves us beyond the simple assertion that mental illness is a brain disease. This does not mean that clients' suffering and difficulties are given less consideration or ignored. Neither does it mean that they are treated in a less empathic way. But it does emphasize the need to view practical, material/instrumental, and social support and environmental accommodations as valuable therapeutic interventions, on a par with more traditional interventions like medication and psychotherapy. Everyday life tasks and skills need to be addressed as part of the practitioners' agenda, as well as if not more than such issues as insight or medication compliance.

Finally, the skills to be assessed and addressed are not only those of conventional psychiatric rehabilitation, such as social skills and employment skills, but the skills involved in establishing and maintaining a comfortable sense of home (on a limited income), skills involved in pursuing pleasant and enjoyable social and recreational activities (with or without others), and skills involved in giving back to others and in sustaining a connection to a sense of meaning and purpose that is greater than oneself.

According to the participants in this study, recovery is hard to plan. In spite of whatever may be developed and implemented as part of treatment and rehabilitation, things happen and people find other, and at times unorthodox, ways to manage their illnesses and re-establish their lives. Participants underscored that practitioners as well as people in recovery need to remain open to opportunities which present themselves, no matter how small, which can make life a bit easier or better, like Paul unexpectedly finding a cat. Understanding recovery in the context of everyday life offers us insights into how people can live full and rewarding lives despite the ongoing presence of long-lasting mental health problems. As a result, it can encourage us to shift from viewing our clients primarily in terms of deviance to becoming equally, if not more, interested in supporting their efforts to function as citizens.

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